

DATE OF REQUEST: _____

KENTUCKY WIC PROGRAM VENDOR APPLICATION

Please Print unless otherwise indicated.

ALL QUESTIONS ON THE APPLICATION MUST BE PROPERLY AND FULLY COMPLETED. PLEASE REVIEW THE WIC INFORMATION MANUAL FOR VENDOR APPLICANTS FOR INSTRUCTIONS ON COMPLETING THIS FORM.

1. STORE NAME _____

2. **PHYSICAL STORE ADDRESS:**

Street # _____ Street Name _____

CITY _____ COUNTY _____ STATE _____ ZIP CODE _____

3. **MAILING ADDRESS (Do not complete if mail can be delivered to the store's physical location.):**

STREET #/ NAME _____

RURAL ROUTE NUMBER/P.O. BOX _____

CITY _____ STATE _____ ZIP CODE _____

4. **STORE TELEPHONE NUMBER:** (_____) _____
Area Code Number

5. **TYPE OF STORE (Check One):** ☐ Grocery ☐ Convenience ☐ Other Specify _____

6. **TYPE OF OWNERSHIP (Check One):** ☐ Single Owner ☐ Partnership ☐ Corporation

7. **OWNERSHIP INFORMATION:**

A. **CORPORATION NAME AND ADDRESS (For any business that is incorporated):**

CONTACT PERSON: _____, _____

TITLE: _____
Last Name First Name

BUSINESS NAME: _____

STREET #/ NAME: _____

P.O. BOX: _____

CITY: _____ STATE: _____ ZIP CODE: _____

TELEPHONE NUMBER: (_____) _____
Area Code Number

Privacy Act Statement: The collection of the Social Security Number (SSN) is authorized by Section 2018 of Title 7, US Code and will be used to determine whether a store qualifies to participate in the WIC Program, to monitor compliance with Program regulations; and for Program management. The provision of the SSN's will be available only to officers and employees whose duties or responsibilities require access for the administration or enforcement of the Special Supplemental Nutrition Program for Women, Infants and Children (WIC Program) and the Food Stamp Act.

B. OWNER(S) NAME(S), SOCIAL SECURITY NUMBER(S) AND TELEPHONE NUMBER(S):

(Complete for single owners, partnerships, principal shareholders of private corporations, corporate officers, etc. Include spouse, if spouse is considered an owner. Attach a listing if more convenient.)

Name _____, _____ SSN _____ Home Phone _____
Last Name First Name

Name _____, _____ SSN _____ Home Phone _____
Last Name First Name

Name _____, _____ SSN _____ Home Phone _____
Last Name First Name

Name _____, _____ SSN _____ Home Phone _____
Last Name First Name

8. **MANAGER (if different from Owner):** _____, _____
Last Name First Name Social Security Number

9. When did (or will) the store open for business under the applying ownership?
Month Day Year

10. How long has this store been in business? _____
Was this store previously operated under another name or owner? ☐ Yes ☐ No
If yes, indicate store name and owner of store:

Name of Store _____ Owner _____
Was the store ever on the WIC Program? ☐ Yes ☐ No

11. Are you (Applicant) related to the previous owner? ☐ Yes ☐ No If yes, what is the relationship: _____

12. Have you (Applicant) ever previously participated in the WIC Program? ☐ Yes ☐ No
If yes, specify the date, the previous authorized WIC number (if known) and the store name (attach a list, if necessary):
Date: _____ Previous WIC Number: _____ Name of Store: _____

13. Including this store, have you (Applicant), the corporation or the manager ever owned, managed or been an employee of a firm which received a warning, was disqualified or terminated from the WIC Program? ☐ Yes ☐ No
If yes, specify the date, the reason and identify the person(s) or corporation, store name and location involved.

Date: _____ Reason: _____
Name of Store: _____ Person(s)/Corporation: _____
Address: _____

14. Do you (Applicant) own or manage any other grocery or drug stores that are currently contracted with WIC? ☐ Yes ☐ No
If yes, list the name and address of the store(s). Attach a list, if necessary.
Name of Store _____ Address: _____

15. Is this store authorized to accept Food Stamps? ☐ Yes ☐ No If yes, Food Stamp Authorization Number: _____
a. If no, has Food Stamp Authorization Application been submitted? ☐ Yes ☐ No
b. Has the Food Stamp Authorization Application been rejected? ☐ Yes ☐ No

16. Including this store, has the Applicant (Owner, the corporation or manager) ever owned or managed a firm which violated the Food Stamp regulations, received a warning letter or was withdrawn, disqualified, assessed a civil money penalty or fined? ☐ Yes ☐ No
If yes, specify the date, the reason, and identify the person(s) or corporation, the store name and location involved.

Date: _____ Reason: _____

Name of Store: _____ Person(s)/Corporation: _____

Address: _____

17. Has the Applicant (Owner, corporation or manager) ever had a license denied, withdrawn, suspended or been fined for license violations (i.e., business or health licenses)? ☐ Yes ☐ No If yes, list the type of license, the reason for and date of denial, fine, suspension, withdrawal or disqualification.

Type of License: _____ Reason: _____ Date: _____

18. BUSINESS ETHICS: Are any of the following now charged with or have they ever been convicted of or had a civil judgment for fraud; antitrust violation; embezzlement, theft or forgery; bribery; falsification or destruction of records; making false statements or claims; receiving stolen property; or obstruction of justice: 1) any partner, 2) owner, 3) any officer, 4) the corporate entity, 5) the manager, or 6) any stockholder who has a substantial role in the operation of the store? If yes, attach a written explanation, giving the name of the person(s) charged or convicted and their relationship to the owner, partner or corporate entity, and their current or past position, if any, in the store or corporation; the court and court docket number, the crime(s) and date(s) committed; the penalty and time served, and any other relevant information.

19. Is there a valid Retail-Food Establishment or Retail Food Store Number in the Owner's name? ☐ Yes ☐ No

Retail-Food Establishment or Retail Food Store Number: _____

20. Is there a pharmacy located within the confines of the store? ☐ Yes ☐ No

21. Indicate the number of cash registers: _____ Do any of these cash registers have optical scanners? ☐ Yes ☐ No

22. IS THIS STORE OPEN YEAR-ROUND? ☐ Yes ☐ No

If NO, check the months when the store is OPEN:

<input type="checkbox"/> January	<input type="checkbox"/> April	<input type="checkbox"/> July	<input type="checkbox"/> October
<input type="checkbox"/> February	<input type="checkbox"/> May	<input type="checkbox"/> August	<input type="checkbox"/> November
<input type="checkbox"/> March	<input type="checkbox"/> June	<input type="checkbox"/> September	<input type="checkbox"/> December

23. HOURS OF BUSINESS:

Monday	___ A.M.	to	___ P.M.
Tuesday	___ A.M.	to	___ P.M.
Wednesday	___ A.M.	to	___ P.M.
Thursday	___ A.M.	to	___ P.M.
Friday	___ A.M.	to	___ P.M.
Saturday	___ A.M.	to	___ P.M.
Sunday	___ A.M.	to	___ P.M.

24. List the bank of deposit that will be used for WIC food instruments and the complete address of the bank:

Bank

Branch Name

Street

City _____ State _____ Zip

25. Provide directions to the store from the Health Department in the county where the store is located (Provide highway numbers rather than stating 'Route 1, etc.').

26. Is the store name visible on the outside of the store? ☐ Yes ☐ No Indicate name on sign or store front if different than name on the front of this application: _____

TO THE BEST OF MY KNOWLEDGE, THE INFORMATION SUPPLIED BY ME ON THIS APPLICATION AND THE ATTACHED PRICE LIST IS CORRECT. IF IT IS DETERMINED THAT THE INFORMATION SUPPLIED IS NOT CORRECT OR THAT, IN REVIEW OF THE INFORMATION SUPPLIED, THE STATE AGENCY FINDS THAT MY STORE DOES NOT MEET THE CRITERIA TO BE A WIC VENDOR, MY STORE WILL NOT BE APPROVED FOR A CONTRACT. I UNDERSTAND THAT, SHOULD MY STORE BE ACCEPTED FOR A WIC CONTRACT, I WILL BE BOUND BY WIC PROGRAM REGULATIONS AND POLICIES. PRIOR TO THE CONSIDERATION OF THIS APPLICATION, I UNDERSTAND THAT I WILL HAVE TO SUPPLY INFORMATION ON GROSS AND FOOD SALES TO THE STATE AGENCY. **I UNDERSTAND THAT THIS IS ONLY A REQUEST FOR AUTHORIZATION AND DOES NOT CONSTITUTE A CONTRACT AND I WILL NOT ACCEPT WIC FOOD INSTRUMENTS UNTIL I HAVE RECEIVED AN APPROVED WIC PROGRAM AGREEMENT AND AN AUTHORIZED WIC VENDOR STAMP.** THIS APPLICATION WILL BE A PERMANENT PART OF MY FILE.

AUTHORIZED SIGNATURE (OWNER OR
CORPORATE OFFICER ONLY)

DATE

TITLE

LOCAL AGENCY USE ONLY

1. **Complete the following by (a) circling yes if the store meets both the “inventory specifications” and “total quantity required in stock” or no if the vendor does not meet the criteria; and (b) circling yes if the store has the prices for food items displayed on the shelf, food item or display case or no if the prices are not clearly displayed. The following information must be obtained during an on-site visit. The on-site visit cannot be performed until the applying owner has actually taken possession of the store and the property transfer has been completed.**

FOOD ITEM	INVENTORY SPECIFICATIONS	TOTAL QUANTITY REQUIRED IN STOCK	INVENTORY IN STOCK	COMMENTS	PRICES MARKED
MILK	2 TYPES REQUIRED - MUST HAVE WHOLE MILK IN GALLON CONTAINERS AND EITHER SKIM OR LOWFAT MILK IN GALLON CONTAINERS MUST BE ABLE TO SUPPLY NONFAT DRY UPON REQUEST	COMBINED QUANTITIES TO EQUAL 8 GALLONS	<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
CHEESE	1 TYPE REQUIRED - MUST BE AVAILABLE IN 8 OZ. OR 16 OZ. PACKAGES, DELI CHEESE ALLOWED	4 POUNDS	<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
EGGS	GRADE A	6 DOZEN	<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
CEREAL	3 PRODUCTS	10 BOXES	<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
JUICE	2 FLAVORS IN 46 OZ. CONTAINERS OR 12 OZ. FROZEN CONCENTRATE-MUST BE 100% JUICE, UNSWEETENED	COMBINED QUANTITIES TO EQUAL 12 CONTAINERS	<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
DRY BEANS OR PEAS	1 TYPE	2 POUNDS-IN ONE (1) POUND PACKAGES	<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
PEANUT BUTTER	1 TYPE REQUIRED	4 - 18 OZ. CONTAINERS	<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
INFANT FORMULA	1 TYPE REQUIRED – MUST HAVE CARNATION GOOD START, FOLLOW-UP OR ALSOY, GOOD START SUPREME, GOOD START SUPREME DHA & ARA, GOOD START ESSENTIALS, GOOD START ESSENTIALS SOY, GOOD START 2 ESSENTIALS, GOOD START 2 ESSENTIALS SOY OR NAN	TOTAL OF 31 CANS OF 13 OZ. CONCENTRATE OR 10 CANS OF 12 OZ. POWDER OR 9 CANS OF 14 OZ. POWDER CONTRACT BRAND	<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
INFANT JUICE	2 FLAVORS IN 4.0 OZ. CONTAINERS	15 CONTAINERS	<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
INFANT CEREAL	1 TYPE REQUIRED	3 BOXES	<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO

2. Verify the Price List with the shelf or display case prices of WIC approved foods. Complete another Price List if corrections are necessary.

3. Are this store's displayed prices the same as the prices on the Price List? ☐ Yes ☐ No

If no, explain: _____

4. Is this store primarily a retail grocery? ☐ Yes ☐ No If no, explain:

Does the store carry other staple food items other than those sold on the WIC Program? ☐ Yes ☐ No

Indicate other items sold at this store:

☐ Gasoline
☐ Hardware

☐ Lottery Tickets
☐ Video Rental

☐ Liquor
☐ Deli

☐ Auto Parts
☐ Bait

5. Have you reviewed with this store the Vendor Agreement and the consequences of Program Abuse? ☐ Yes ☐ No

6. **Warn vendor applicant that he/she is not an Authorized WIC Vendor and cannot accept food instruments until the authorized stamp is obtained and initial training completed.**

I CERTIFY THAT I HAVE VISITED THIS STORE AND FIND IT (ELIGIBLE/NOT ELIGIBLE) BASED UPON THE CRITERIA FOR SELECTION OF VENDORS AND THE VENDOR AGREEMENT. IF THIS VENDOR APPLICANT IS NOT ELIGIBLE, PLEASE DOCUMENT WHY:

SIGNATURE OF LOCAL AGENCY REVIEWER _____

DATE

STATE AGENCY USE ONLY

1. Are the Food Prices Commensurate? ☐ Yes ☐ No

2. Date Food Stamp information verified with appropriate Food Stamp Office: _____

Food Stamp Number: _____

3. Check type of permit. Retail-Food Establishment Number: _____

Retail Food Store Number: _____ Indicate Date Verified: _____

4. Does the vendor meet the Criteria for Selection of Vendors? ☐ Yes ☐ No

If no, explain: _____

5. Recommended for approval? ☐ Yes ☐ No

6. Additional Comments:

7. Signature _____ Date _____